

Prospective MCO Vendor Questions & Answers

1. Please clarify / define Contract Mix and Average Contract Size for years 2007, 2008 and 2009 on Table C1 (pg 41) of the RFP request.

Contract mix refers to the percentage of contracts which are comprised of single and family enrollment, respectively. These are components of the premium rate development which the State requests annually with MCO renewals.

2. Please provide current benefit summaries for each carrier.

This is not available electronically; one of the improvements we will be seeking with any new or continuing vendors is improved benefit certificate communication both to employees and the employer. The current plan is described in Section 1.1 and in the proposed contract provided with the RFP.

3. Please provide enrollment to match the claims experience for each carrier in the form of contracts and contract type (single / family).

All of the information that is currently available has been released with the Request for Proposal. If additional information that would be beneficial to the proposal process becomes available prior to the due date, we will release it to all vendors.

4. Please provide the number of contracts by carrier that are eligible for Medicare Part D coverage.

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5. Please provide individual large claims over \$10,000 (or at minimum individual large claims listing over \$37,500) matching the claims experience periods for each carrier. All claims should include diagnosis. Please provide case management notes for all individual large claimants over \$100,000 and for any individual large claimant with a diagnosis that has the potential of claims over \$100,000.

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6. Please provide the total premium for each carrier's claims experience periods to correspond with the monthly enrollment.

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7. Should the response to Question # 12 in Section 8.2 on page 44 include a scenario for 3 Providers given the recent sale of John Deere Health to United Healthcare?

Prospective vendors can make any assumptions necessary to respond to Question #12 in Section 8.2 so long as these assumptions are provided.

8. Please provide Network Savings by carrier.

We consider this information to be proprietary to each carrier. In addition, as the State of Iowa MCO contracts are currently under fully-insured arrangements, the precise level of network discounts as a percentage is not known.

9. Please provide an updated census matching the 10,878 total MCO contracts listed in the introduction section 1.1 of the RFP Request. Also, please clarify the additional MCO Health Codes included in the census of 28,507 that was provided in Attachment 9 of the RFP Request.

The census provided the entire population of contract holders. The Code Definition page provided the tools for reducing the census down to MCO participants only. This was done so that prospective vendors could get a feel for the breadth of employees they could gain access to, and potentially cover.

10. Is the RFP requesting a MCO Service Area analysis or a Disruption Analysis? If a Disruption Analysis is being requested, we would need claims data from the other MCO plans which would include –provider name, tax i.d number, address, state, and zip code to match against the Wellmark Health Plan of Iowa network. In addition if the amount paid per provider data is available that would also be helpful.

At this time, the State is not requesting a disruption analysis. We reserve the right to request such an analysis from vendors who are named as finalists.

11. What is process at renewal for Employee open enrollment notification, e.g. will there be meetings, network communication, or written notification? Will vendors have avenue to 'market' their benefits to State employees?

At this time enrollment and change periods are handled through the DAS-HRE developed documents and our website. As the State's budget has been reduced, large vendor employee marketing forums have been eliminated. Since benefits are standardized for MCOs, vendor marketing comes down to network and price.

12. If we now offer both PCP and open access networks, determine it's best to just present open access plan for 2007 -- what will be process of moving current PCP members? Will they have direct marketing contact to advise of their change, or just default to carriers' remaining open access product?

Employees are told of options available during the Enrollment and Change period as described in #11. If a current carrier wishes to send out marketing materials to current enrollees, that is within their right now and would be within their right in the future.

13. The RFP indicates no benefit changes. However, the following changes were noted:

- A. We note Section 1, Page 2, Mental Health Substance Abuse Inpatient. It appears it's stated both 80% and 100% inpatient coverage. Current coverage 80%. Clarify inpatient MHSA for 2007.

Inpatient MH for 2007 is 0% coinsurance for the member.

Inpatient SA for 2007 continues to be 20% coinsurance for the member.

- B. Respiratory Therapy, Section 1, Page 3, Current coverage is 20 visits per calendar year. 2007 RFP moves to 'short term therapy', same as other short term therapies (which would be 60 days calendar year). Is Respiratory Therapy to increase number of days covered?

Current coverage is 60 visits per member per year.

- C. Speech, Occ. & Physical Therapy, Section 1, Page 3. Current coverage is Maximum 60 visits per therapy per year. In 2007, we add respiratory therapy -- correct. And do we change it to 60 days accumulative for all therapies, as stated in 2007 RFP, or keep at 60 visits PER THERAPY per year?

Current coverage for Respiratory, Speech, Occ., and Physical Therapy is 60 visits per member per year per therapy and will continue that way for 2007.

14. Medicare eligible retirees over 65 - will they remain as current, e.g. same benefits as active? No mention is made of any plan to move these to a Medicare Advantra or Plan D coverage. Please clarify intent for 2007 coverage.

At this time we anticipate that post 65 retirees will have the same medical and pharmacy benefits as actives; however, we are interested in prospective vendors' ability to "wrap" our benefits with Medicare Part D. The State wants vendors to be able to coordinate with a Part D provider so that Medicare D is primary but retirees see no difference to their pharmacy benefits from current benefit levels.

15. Is putting premium at risk a condition of quoting? If it is, what is the criteria?

Yes, performance guarantees are required for any State contract per the Iowa Accountable Government Act. There are, however, no set rules on the performance levels or amounts at risk.

16. Section 7: Proposal Questionnaire, Para. 7.5 Performance Criteria. Clarify anticipated information needed in Vendor Comments column. Are you asking if we can do the things lists, will we do them, or what do you specifically need?

Please indicate “agreed” in the comments column of the Performance Criteria table if you are agreeable to the requested performance standards and penalties. If you cannot meet the requested criteria, please clearly indicate any proposed alternatives in the comments column.

17. What is the 2004 and 2005 monthly covered membership counts for the current HMO plans?

All of the information that is currently available has been released with the Request for Proposal. If additional information that would be beneficial to the proposal process becomes available prior to the due date, we will release it to all vendors.

18. What are the monthly capitation expenses, for 2004 and 2005, for the current HMO Plans?

We are unable to release this information due to its proprietary nature to each carrier.

19. Is large claim activity (claims exceeding \$100,00; diagnosis and prognosis) for 2004 and 2005 available for review?

All of the information that is currently available has been released with the Request for Proposal. If additional information that would be beneficial to the proposal process becomes available prior to the due date, we will release it to all vendors.

20. What factors will the Insurance Division consider when determining the following qualification?

In regard to Section 4.3 Minimum Bidder Qualifications

- Ability to provide a medical provider network that covers at least 50 percent of the State's counties as determined by the Iowa Insurance Division

This qualification is determined by the Iowa Insurance Division in conjunction with its partners. Any questions related to this determination should be directed to the Iowa Insurance Division.

21. Will RFP's be considered from incumbent State of Iowa carriers who do not have physician networks in 50% of Iowa Counties?

No

22. Will RFP's be considered from non-incumbent State of Iowa carriers who do not have physician networks in 50% of Iowa Counties?

No

23. Please provide more detail so that we are able to answer the following question appropriately.

In regard to Section 7.4 Network Accessibility and Disruption, Question #70

- Is any part of your network leased?

This question is asking you to indicate if you lease or rent any part of your provider (both physician and hospital) network from any other organization. If your organization holds contracts with all of your network providers directly, please indicate that in your answer.

24. What is the pooling level the State of Iowa would like to be included in the pricing?

We request that vendors utilize standard book of business pooling levels for a group similar in size and composition to the State of Iowa. Historically, the State's MCOs have had pooling levels between \$75,000 and \$400,000

25. Please provide retiree claim experience and a complete retiree census.

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